

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH) Docket No. NH20-C0064
STATE OF ILLINOIS,)
Complainant,)
v.)
LEXINGTON HEALTH CARE CENTER OF)
ORLAND PARK, INC.,)
D/B/A, LEXINGTON OF ORLAND PARK,)
Respondent.)

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED;
NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF
VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.)
(hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint IL00119263 Investigation conducted by the Department on January 22, 2020, at Lexington of Orland Park, 14601 South John Humphrey Drive, Orland Park, Illinois 60462. On March 25, 2020, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

- 1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.

- 2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
- 3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of \$ 2,200.00, as follows:

Type B violation of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b)5), 300.1210d)6), and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high-risk designation: 300.1210b), 300.1210d)6), and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Attn: Sammye Geer
Illinois Department of Public Health
525 West Jefferson, 5th Floor, QA
Springfield, Illinois 62761

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

- (A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.
- (B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or
- (C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING


Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

Plan of Correction, Hearing Requests and Waivers can be emailed to the following email address: DPH.LTCOA.POChearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.



Aimee Isham
Bureau Chief, Long Term Care
Office of Health Care Regulation

Dated this 26th day of March, 2020.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

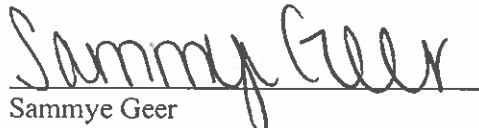
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PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent: James Samatas
Licensee Info: Lexington Health Care Center of Orland Park, Inc.
Address: 665 West North Avenue
Lombard, Illinois 60148

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the
26th day of March, 2020.


Sammye Geer
Administrative Assistant I
Long Term Care – Quality Assurance
Office of Health Care Regulations

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014682	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/22/2020
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NAME OF PROVIDER OR SUPPLIER LEXINGTON OF ORLAND PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 14601 SOUTH JOHN HUMPHREY DR ORLAND PARK, IL 60462
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S9999	<p>Final Observations</p> <p>Investigation of Complaint 2070395/IL00119263</p> <p>Statement of Licensure Violation:</p> <p>300.610a) 300.1210b)5) 300.1210d)6) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	
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Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

02/03/20

Illinois Department of Public Health

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S9999	<p>Continued From page 1</p> <p>5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to ensure safety measures were in place and working correctly to prevent falls for a resident identified as high risk for falls. This failure resulted in (R1) being hospitalized after a fall and sustaining multiple facial fractures and abrasions.</p> <p>This applies to 2 of 3 residents (R1, and R3) reviewed for falls in the sample of 3.</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>The findings include:</p> <p>1. Review of R1's EHR (Electronic Health Record) showed R1 was originally admitted to the facility 6/6/15 with diagnoses that included hypertension, dementia, osteoporosis, repeated falls, cognitive communication deficit and need for assistance with personal care. R1's annual MDS (Minimum Data Set) dated 10/14/19 showed R1 required extensive assistance of one-person physical assist with transfer and toilet use. The MDS shows R1 with impairment on both sides of the lower extremities.</p> <p>Review of R1's fall risk evaluation dated 6/12/19 showed R1 with a score of 16=High Risk for fall. Review of R1's fall risk evaluation dated 8/14/19 showed R1 with a score of 16=High Risk for fall. There was no fall risk evaluation done for R1 in (next quarter) November 2019.</p> <p>On 1/21/2020 at 9:10am, V10 (Hospital Social Worker) stated R1 was received at the hospital's emergency room on 1/16/2020 with multiple facial fractures. V10 stated R1 is presently admitted to the hospital and undergoing treatments for the injuries sustained from the fall.</p> <p>Review of R1's clinical notes dated 1/16/2020 and authored by V3 (Nurse) showed on 1/16/2020, V3 was walking down the hallway when she heard R1 crying out in pain". The note showed V3 opened R1's door to observe R1 on the floor lying on left side at the foot of the bed". The clinical note also shows (R1) noted with laceration to right forehead and bridge of nose, both sides actively bleeding, The note also shows R1 with left arm skin tear on elbow.</p> <p>Review of R1's physician order sheet (POS) has</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>an order dated 2/1/19 for "Bed alarm-check for placement and proper functioning".</p> <p>Review of R1's care plan created 10/3/19 shows R1 at risk for falls as related to dementia, limited transitioning and balance performance, history of limited range of motion to bilateral lower extremities, nutritional health, anemia, diuretic prescribed, incontinence, hypertension, osteoporosis, osteoarthritis, difficulty hearing at times, other abnormalities of gait and mobility, repeated falls, muscle wasting, atrophy and abnormal posture. The care plan shows: "Bed alarm ordered and check for proper functioning when in use".</p> <p>Review of restorative nursing program progress note dated 12/13/19 shows R1 "requires extensive assistance to complete most activities of daily living (ADL)". The note also shows R1 needs one person assistance to complete her transfers.</p> <p>Review of R1's incident report dated 1/16/2020 showed at around 2am, R1 was "observed on the floor next to the bed. R1 stated that she fell getting back in bed. The report further showed, R1 was sent to the hospital". The report also showed R1 was admitted to the hospital with multiple facial fractures.</p> <p>Review of hospital records show computed tomography (CT) of head for R1 with "Right periorbital soft tissue swelling with edema also noted overlying the nasal ridge and nasal bones. Moderate partial opacification of the paranasal sinuses with several collections of air identified in the soft tissues of the face consistent with underlying facial bone fractures". CT of R1's facial bones without contrast shows R1 with</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>multiple bilateral facial bone fractures with moderate to severe opacification of the paranasal sinuses. R1 also noted with small frontal scalp hematoma with laceration and mild to moderate right periorbital soft tissue swelling consistent with posttraumatic edema, bilateral nasal bone fractures. Acute fracture noted along the anterior and posterior lateral walls.</p> <p>The hospital record dated 1/16/2020 showed R1 with clinical impression of: Fall, closed head injury, laceration of nose, right eyelid laceration, laceration of forehead, multiple closed fractures of facial bone.</p> <p>On 1/21/2020 at 11am, V6 (Restorative Nurse) stated fall risk assessments are done by nursing staff on resident's admission, quarterly, annually and with each fall or significant change.</p> <p>On 1/21/2020 at 12:11pm, V2 Acting DON (Director of Nursing) stated residents with risk assessment fall score of 10 and above are considered high risk for fall. V2 stated nursing staff are expected to pay extra attention to such residents, apply a red dot by the name on resident's door, perform appropriate interventions like assist in toileting. V2 stated nursing staff are trained to properly fill out resident's risk assessment form and are responsible for completing the forms as expected after each fall, on admission, and quarterly.</p> <p>On 1/21/2020 at 2:29pm, V5 CNA (Certified Nursing Assistant) stated she is the regular staff that cares for R1 on night shift. V5 stated R1 is high risk for fall. V5 stated R1 always requires extensive assist of one staff to go to the bathroom or move in and out of the bed. V5 stated on 1/15/2020 at 10pm, she observed R1</p>	S9999		
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S9999 Continued From page 5 S9999

trying to move her legs out of bed when she went in R1's room to provide R1 with assistance to the bathroom. V5 stated she could not recall if R1 was placed on bed alarm at that point. V5 stated she was not sure if R1 was supposed to have bed alarm on and did not place R1 on bed alarm after returning from the bathroom. V5 stated around 2am on 1/16/2020, she was called by V3 (Nurse) to come to R1's room, she also saw other staff members rushing towards R1's room. V5 stated on getting there, R1 was on the floor bleeding.

On 1/21/2020 at 2:44pm, V4 (Night Nurse Supervisor) stated she was rounding on the floor when she was alerted to R1's fall. V4 stated she assisted in providing first aid to R1 because of the extent of her injuries. V4 stated if resident is high risk for fall, they are supposed to have bed in low position, mat on the floor, and alarms on if ordered. V4 stated she was not sure if R1 had a floor mat on 1/16/2020 because R1's bed had been pushed aside to accommodate staff providing first aid to R1.

On 1/21/2020 at 3:25pm, V3 (Nurse) stated she was not familiar with R1 and could not recall if she ever took care of R1 prior to 1/16/2020. V3 stated on 1/16/2020 at 2am, she was walking in the hallway when she heard R1 crying with pain. V3 stated she opened R1's door and found R1 on the floor on her left side by the foot of the bed face down and bleeding. V3 stated R1 was saying, "I fell, I fell". V3 stated R1's cry drew her attention to R1's room and she did not hear a bed alarm activation. V3 stated R1 was supposed to have an alarm on. V3 stated she does not really work with R1 and was not sure if R1 needed help to the bathroom. V3 stated R1 had gone to the bathroom herself and was returning to bed when she fell. V3 stated she called the physician and

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S9999	<p>Continued From page 6</p> <p>was asked to send R1 out because of the injuries. V3 stated R1 is a high risk for fall.</p> <p>On 1/22/2020, at 12:27pm, V11 (Physician) stated she saw R1 on 1/17/2020 and today (1/22/2020) at the hospital. V11 stated R1's injuries are very extensive. V11 stated R1 was not going to have surgery due to her age (100 years old). V11 stated she expects the facility to care extensively for R1 when providing care because R1 has dementia and would not be able to comprehend instructions. V11 stated she would expect nursing staff to carry out any order written in the POS.</p> <p>On 1/22/2020 at 12:42pm, V2 (DON) further stated bed alarm orders and other fall prevention interventions should be followed if it was active in the POS and the care plan. V2 stated nursing staff are expected to familiarize themselves with resident's care plan.</p> <p>2. R3's EHR shows R3 was admitted to the facility on 10/3/17 with diagnoses that included atrial fibrillation, cardiac pacemaker, repeated falls, altered mental status, syncope, collapse, sepsis and dementia. R3's MDS dated 1/5/2020 shows R3 requires extensive assistance of one to two persons physical assist with bed mobility, transfer, personal hygiene, and toilet use.</p> <p>R3's care plan created 1/6/2020 shows, R3 is at risk for falls due to status post pneumonia, muscle wasting, and atrophy, need for assistance with personal care, repeated falls, history of malnutrition, limited transitioning and balance performance, incontinence, arthritis, cardiovascular diseases, hypothyroidism, and dementia. The care plan intervention included: Bed alarm ordered and check for proper functioning when in use.</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>Review of R3's fall risk evaluation dated 9/8/19 showed R3 with a score of 11=High Risk for fall. Review of R3's fall risk evaluation dated 12/10/19 showed R3 with a score of 18=High Risk for fall. Review of R3's fall risk evaluation dated 1/14/2020 showed R3 with a score of 13=High Risk for fall.</p> <p>On 1/21/2020 at 1:30pm, R3 was observed in bed. R3's bed was high and R3 did not have bed alarm on or floor mat around her bed. R3 was alert but slightly confused.</p> <p>On 1/21/2020 at 1:33pm, V9 (CNA) stated R3 is high risk for falls and was supposed to have bed alarms on and floor mat around her bed. V9 stated she did not know why R3 did not have these things on.</p> <p>Review of facility's policy titled, 'Fall Management' with a revised date 6/4/14 shows, the facility observes the physical and cognitive function of each resident to identify factors that place them at risk for falling. A care plan is developed defining those risks and interventions are implemented. The policy also shows 3. A score of 10 or higher is indicative of a risk for falls. 5. The facility will observe for the use of safety devices always selecting the least restrictive device to meet the individualized needs of the resident. 6. The care plan is developed to address the areas identified on the review and on the observations of the resident.</p> <p>(B)</p>	S9999		
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